

**JOURNEY COUNSELING WACO**  
**Waco, Texas**  
**COUNSELING INFORMATION AND CONSENT**

Thank you for selecting our Counseling Center. This consent form explains some important information about our counseling procedures. Your therapist is a licensed professional counselor and will review this information with you in your first session at which time you will be asked if you understand our Center policies and your treatment.

**CONFIDENTIALITY** The Center is committed to confidentiality and the privileged communication of all clients. According to Texas law, however, therapists “having cause to believe” that a child, disabled person(s), or an elderly person is being abused are required to report that information to the Texas Department of Human Services. Also, if any individual intends to take harmful, dangerous or criminal action against another person, or against himself, it is the therapist’s duty to report such action or intent.

( \_\_\_\_\_ )  
**Client Initials**

**APPOINTMENTS** can be made by calling (254) 498-6495. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. We ask that you give two weeks’ notice if you plan to terminate treatment.

**FEES** Our fee is \$105.00 for a 50-minute session. Your therapist may suggest consultation, psychological testing and/or psychiatric evaluation for which you will be responsible. If you cannot afford the regular fee, an adjusted fee based on your family size and income may be available. Fee or co-payment is due at the time services are provided. You are responsible for full payment of your account, including the amount due if an insurance claim is denied for any reason, within thirty days after the date the claim is denied.

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**Client Initials**

**EMERGENCIES** The Center does not provide “emergency service.” If you have an urgent concern we try to schedule an appointment as soon as possible. If you have a critical emergency requiring immediate attention after hours contact one of the following: The DePaul Center (254) 776-5970, or go directly to the Providence Hospital emergency room.

**CONSULTATION** between partners and for the purpose of supervision, consultation, or peer review, will be protected in accordance with professional ethics and confidentiality.

**CONSUMER COMPLAINTS**

For all Texas licensed/certified professionals: (800) 942-5540

Texas Department of Insurance (800) 252-3439  
PO Box 149104 Fax (512) 475-1771  
Austin, TX 78714-9104

U.S. Department of Human Services (877) 696-6775  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 200201

**CONSENT TO TREATMENT** I voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

My signature affirms that I have read or heard the information above and that it was presented to me in clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to this treatment.

\_\_\_\_\_  
Client’s Signature (or Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist’s Signature

\_\_\_\_\_  
Date